

## CLINIC DATE:\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
                     Street or P.O. Box                      City                      Zip

IF REQUESTING TB SKIN TEST, RESULTS OF PREVIOUS SKIN TEST: Negative \_\_\_\_ Positive \_\_\_\_ Date: \_\_\_\_\_

**FOR NURSES USE ONLY:**

MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #
<b>HEP A</b>	<b>HEP B</b>	<b>HEP B</b>	<b>TWINRIX</b>	<b>Td</b>	<b>TdaP</b>	<b>MMR</b>	<b>PNEUMONIA</b>
1 2	1 2 3 4	<i>TITER</i>	<i>(Hep A &amp; B)</i>	1 2 3	<b>Boostrix Adacel</b>	1 2	1 2
		Positive	1 2 3		(10-18 YRS) (11-55 YRS)		
<u><i>SITE:</i></u>	<u><i>SITE:</i></u>	Negative	<u><i>SITE:</i></u>	<u><i>SITE:</i></u>	<u><i>SITE:</i></u>	<u><i>SITE:</i></u>	<u><i>SITE:</i></u>
RDIM	RDIM	<b><u>RESULT</u></b>	RDIM	RDIM	RDIM	RASQ	RDIM
LDIM	LDIM		LDIM	LDIM	LDIM	LASQ	LDIM

MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #	MFG LOT #
<b>VARICELLA</b>	<b>IPV</b>	<b>YELLOW FEVER</b>	<b>TYPHOID</b>	<b>TB</b>	<b>TB RESULTS</b>	<b>MENINGOCOCCAL MENINGITIS</b>
1 2	1 2 3 4	1 2	1 2			1 2
<u>SITE:</u>	<u>SITE:</u>	<u>SITE:</u>	<u>SITE:</u>	<u>SITE:</u>	Positive	<u>SITE:</u>
RASQ	RASQ	RASQ	RDIM	LAV	Negative	<b><u>Menactra</u></b> <b><u>Menomune</u></b>
LASQ	LASQ	LASQ	LDIM		_____ mm	LDIM RASQ
			ORAL		Checked by:	RDIM LASQ
					_____	

MFG LOT #	MFG LOT #	MFG LOT #	Nurses Signature: _____  Date: _____  Comments:
<b>FLU</b> <u>SITE:</u> LDIM RDIM			

Liz/forms/adult iz sheet 7-26-05

Name: \_\_\_\_\_

**ACKNOWLEDGEMENT AND CONSENT – PLEASE INITIAL**

- \_\_\_\_\_ I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.
- \_\_\_\_\_ I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.
- \_\_\_\_\_ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.
- \_\_\_\_\_ I consent to the shared use of demographic information that is provided for immunization health purposes.

**The following questions will help us determine which vaccine may be given in clinic today. Please answer these questions by checking the boxes. If the question is not clear, please ask the nurse to explain it.**

	YES	NO	DON'T KNOW
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, eggs, any vaccine or any vaccine component? <input type="checkbox"/> Gelatin (Varicella, Yellow Fever) <input type="checkbox"/> Neomycin (MMR, IPV, Varicella) <input type="checkbox"/> Streptomycin/Polymixin B (IPV) <input type="checkbox"/> Thimerosal (a mercury derivative) (Flu) <input type="checkbox"/> Latex (Flu)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past year have you received a transfusion of blood or plasma, organ or stem cell transplant or been given a medicine called immune globulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. For women: Is it possible that you are pregnant or may become pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any live virus vaccine in the past 30 days (measles, mumps, rubella, yellow fever, chickenpox)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Did you bring your immunization record card with you? Yes ☐ No ☐**

It is important for you to have a personal record of your shots. If you don't have a record card, ask your doctor or nurse to give you one! Bring this record with you to your clinic visits. Make sure your nurse records all your vaccinations on it.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date